Sample Request Form

Mylan Pharmaceuticals Inc. USE ONLY	
Processed by:	Date:
Order #	
Prescriber #	
Rejected by:	Date:
Reason:	
Sales Rep:	Date:
Signature:	
Territory Number:	

FAX TO: Mylan Specialty L.P. Attn: Customer Relations
FAX #: 1-304-285-6418

Healthcare Professional (HCP) Sample Request Form for:

PRODUCT NAME	ESTABLISHED NAME/STRENGTH	SIZE/UNIT	QTY	CLASS	NDC	ERPID
MUSE®	(alprostadil) Urethral Suppository, 125 mcg	1 Box of 6 pouches	1	Rx	0037-8110-56	2010
MUSE®	(alprostadil) Urethral Suppository, 250 mcg	1 Box of 6 pouches	1	Rx	0037-8120-56	2020
MUSE®	(alprostadil) Urethral Suppository, 500 mcg	1 Box of 6 pouches	1	Rx	0037-8130-56	2030
MUSE®	(alprostadil) Urethral Suppository, 1,000 mcg	1 Box of 6 pouches	1	Rx	0037-8140-56	2040

Manufactured and distributed by Meda Pharmaceuticals a division of Mylan Specialty L.P.

You will receive one (1) sample as shown to the left while supplies last.

Only one (1) form can be submitted per month.

Healthcare Professional's Name ____________________
Please Print (First Name) (Middle Initial) (Last Name)

Professional Designation: ☐MD ☐DO ☐PA ☐NP HCP's State License #: ____________ State: ☐☐

Address (no PO Box #): ____________________

City: ____________ State: ☐☐ Zip: ☐☐☐☐☐-☐☐☐☐
Note: Shipments will only be made to a registered state license address. For Ohio HCPs, the address must match the TDDD license.

Phone: ☐☐☐-☐☐☐-☐☐☐☐ Fax: ☐☐☐-☐☐☐-☐☐☐☐

I certify, by signing below, that I am a licensed practitioner authorized by state and federal law to prescribe, request and receive these drug samples. I am requesting these samples for the medical needs of my patients and will not sell, purchase, trade, barter, return for credit, or offer to do so, or seek reimbursement for these samples.

HCP's Signature: ____________________ Date: ____________
(HCP must sign and date. Stamped signature not accepted.)

MANDATORY SUBSECTION FOR ALL OHIO HCPs

Under Ohio law, Mylan Specialty L.P., which holds wholesale distributor license number 012304150 (expiring June 30, 2019), may only provide drug samples to prescriber's whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity, including prescriber practices, to receive, purchase, and possess prescription drugs and controlled substances, including drug samples, for distribution to patients. Not all prescriber practices, however, are required to obtain a TDDD license. For example, subject to certain exceptions, an individual prescriber doing business as a sole proprietor (not incorporated in any manner) or a practice that is a corporation, limited liability company, or professional association where a prescriber is the sole shareholder and is authorized to provide the professional services being offered by the practice are exempt from obtaining a TDDD license. For a complete list of exemptions, please refer to section 4729.541 of the ORC. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at www.pharmacy.ohio.gov/PrescriberTDDD. The above information is being provided for your convenience and is not offered as, nor should it be construed as, legal advice.

Please select and complete one of the following:

☐ The practice at which I work, [insert name] ____________, located at the address I provided above, has an active TDDD license that allows me to receive and store the requested samples at this location. The TDDD license number is ____________ and expires on ____________.

OR

☐ The practice at which I work, [insert name] ____________, located at the address I provided above, is subject to one of the TDDD licensing exemptions in ORC § 4729.541.

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested samples at the address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

HCP's Signature: ____________________ Date: ____________
(HCP must sign and date. Stamped signature not accepted.)

In compliance with the "Prescription Drug Marketing Act", ONLY valid, COMPLETED, SIGNED, and DATED Sample Requests will be processed. In addition, Healthcare Professional or authorized designee must sign, date, and fax Acknowledgement of Contents form to Mylan Specialty L.P. upon delivery of sample shipment.

This sample request form is only valid until 6/30/2019. Expired forms will not be processed.